STANDARDS OF CARE

Los Angeles County Commission on HIV

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STANDARDS OF CARE

Los Angeles County Commission on HIV

PSYCHOSOCIAL CASE MANAGEMENT SERVICES

EXECUTIVE SUMMARY

SERVICE INTRODUCTION

Psychosocial case management services can include both individual and family interventions. To be eligible for services, at least one member of the family must be living with HIV. Services to the non-infected members of the family unit shall have at least indirect benefit to the member living with HIV/AIDS by enhancing the health status of this family member. Psychosocial case management services are client-centered activities through which care for persons living with HIV is coordinated. Family case management services are designed to maintain, enhance or promote family stability and the functional integrity.

Psychosocial case management services may include:

- Intake and assessment of available resources and needs
- Development and implementation of service plans
- Coordination of services
- Interventions on behalf of the client or family
- Linked referral
- Active, ongoing monitoring and follow-up
- Periodic reassessment of status and needs

The goals of psychosocial case management services include increasing self-efficacy; facilitating access and adherence to primary health care; facilitating access and linkage to appropriate services and to the continuum of care; increasing access to HIV information and education; and identifying resources and increasing coordination between providers.

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

At present, psychosocial case management services are unlicensed. All psychosocial case management services will be provided in accordance with Commission on HIV guidelines and procedures, and local laws and regulations.

SERVICE CONSIDERATIONS

General Considerations: Psychosocial case management services will respect the inherent dignity of the client. Services will be client-driven, aiming to increase a client's sense of empowerment, self-advocacy and medical self-management, as well as enhance the overall health status of people living with HIV. All psychosocial case management will be culturally and linguistically appropriate to the target population.

Outreach: Programs providing psychosocial case management services will conduct outreach to educate potential patients, HIV services providers and other supportive service organizations about the availability and benefits of medical case management services for people living with HIV in Los Angeles County.

Eligibility: Programs will develop and implement eligibility requirements that give priority to clients or families living at or below 100% of poverty level and with the greatest health and service need.

Intake: Client or family intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client

Comprehensive Assessment and Reassessment: Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Assessment/ reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs and resources.

Clients learn to develop personal support systems.

Client Acuity Level Assessment: Client acuity levels (for individuals) will be assessed using all components of the comprehensive assessment and based upon a client's level of functioning and/or current need. Case management services will be offered to all clients who meet "high" or "transitional" acuity levels. Other clients will be referred to other sources of care.

Individual Service Plan (ISP) or Family Service Plan (FSP): In conjunction with the client or family, an ISP is developed that determines the case management goals to be reached.

Implementation of Service Plan, Monitoring and Follow-Up: Implementation, monitoring and follow-up involve ongoing contact and interventions with (or on behalf of) the client or family to achieve the goals detailed on the ISP, evaluate whether services are consistent with the ISP and determine any changes in the client's status that require updates to the ISP.

Client Retention: Programs shall strive to retain clients or families in psychosocial case management services. A broken appointment policy and procedure to ensure continuity of service and retention of patients is required.

Case Conferences: Case closure is a systematic process for disenrolling clients or families from psychosocial case management services; the process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record.

Case Closure: Case closure is a systematic process for disenrolling clients or families from case management, psychosocial services. The process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record.

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all psychosocial case management staff will be able to provide linguistically and culturally appropriate care to people living with HIV and complete documentation as required by their positions. Case management staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations.

Case managers will hold a Bachelor's degree in an area of human services; a high school diploma (or general education development (GED) equivalent) and at least one year's experience working as an HIV case manager or at least three years' experience working within a related health services field. All case managers will successfully complete the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy (OAPP)—Case Management Certification Training within six months of being hired, as well as all recertifications and requisite training (as appropriate). Periodic staff training is required to ensure the continued delivery of quality services. Programs will provide and/or allow access to ongoing staff development and training for case management staff. Case managers will participate in at least eight hours of job-related education or training annually.

Case management supervision will be provided by a Master's degree-level mental health professional (social work, counseling, nursing with specialized mental health training, psychology, or Doctoral candidate in any of these fields) with case management experience and appropriate professional credentials.





STANDARDS OF CARE

Los Angeles County Commission on HIV

PSYCHOSOCIAL CASE MANAGEMENT SERVICES

SERVICE INTRODUCTION

Psychosocial case management services can include both individual and family interventions. Psychosocial case management services are client-centered activities through which care for persons living with HIV is coordinated. Family case management services are designed to maintain, enhance or promote family stability and the functional integrity.

Psychosocial case management services may include:

- Intake and assessment of available resources and needs
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- Coordination of services
- Interventions on behalf of the client or family
- Linked referral
- Active, ongoing monitoring and follow-up
- Periodic reassessment of status and needs

All programs will use available standards of care to inform clients of their services and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and its importance cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

The goals of psychosocial case management services include:

- Increasing self-efficacy
- Facilitating access and adherence to primary health care
- Facilitating access and linkage to appropriate services and to the continuum of care
- Increasing access to HIV information and education
- Identifying resources and increasing coordination between providers

The Los Angeles County Commission on HIV and the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy (OAPP)—have developed this standard of care to set minimum quality expectations for service provision and to guarantee clients consistent care, regardless of where they receive services in the County.

Programs support HIV education.

Recurring themes in this standard include:

- Psychosocial case management will respect the dignity and self determination of clients.
- Services will be delivered to support and enhance a client's self-sufficiency.
- All services will be based on a comprehensive psychosocial intake, around which service plans and implementation activities are developed.
- Ongoing monitoring of progress towards completion of goals is an integral part of case management services.
- Case management staff require specialized training and ongoing client-care related supervision.
- Case managers will consider the client's self-identified family in the provision of services.

This document represents a synthesis of published standards and research, including:

- *HIV/AIDS Psychosocial Case Management Standard of Care*, Case Management Task Force of Los Angeles County, 2004
- *Case Management, Psychosocial Contract Exhibit*, Office of AIDS Programs and Policy
- *Case Management, Psychosocial Family Case Management Contract Exhibit,* Office of AIDS Programs and Policy
- Standards of care developed by several other Ryan White Title 1 Planning Councils. Most valuable in the drafting of this standard were Baltimore, 2004; San Antonio, 2005; Portland, 2005; and Las Vegas

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

At present, all psychosocial case management services are unlicensed. All psychosocial case management services will be provided in accordance with Commission on HIV guidelines and procedures, and local laws and regulations.

Case managers will successfully complete DHSP's HIV Case Management Certification Training and participate in all required recertification activities and training. A case management-experienced, Master's degree-level or Doctoral candidate mental health professional will provide ongoing client care-related supervision for all case managers.

DEFINITIONS AND DESCRIPTIONS

Adults-only family will be broadly defined to include any individual affected by HIV disease through his or her relationship and shared household with a person living with HIV.

Assessment is a cooperative and interactive face-to-face interview process during which the client's medical, physical, psychosocial, environmental and financial strengths, needs and resources are identified and evaluated.

Case closure is the systematic process of disenrolling clients from active case management services.

Client intake is the process that determines a person's eligibility for case management services.

Families with children include at least one child and one adult parent or guardian. To be

eligible for psychosocial case management services, at least one member of the family must be living with HIV.

Family Service Plans (FSPs) detail family goals and objectives based on the needs identified in the comprehensive assessment or reassessment.

Individual Service Plans (ISPs) detail client goals and objectives based on the needs identified in the comprehensive assessment or reassessment.

Outreach promotes the availability of and access to psychosocial case management services to potential clients and service providers.

Reassessment is an opportunity to periodically reassess a client or family's needs and progress in meeting the objectives as established within the ISP.

Services help improve quality of life.

HOW SERVICE RELATES TO HIV

At the end of 2013, approximately 60,050 people were estimated to be living with HIV infection in Los Angeles County. Los Angeles County comprises 40% of the total AIDS cases in the State of California (Epidemiologic Profile of HIV in Los Angeles County, 2013).

Case management services have been shown to be an essential component in the comprehensive care of people living with HIV (Mitchell & Linsk, 2001). The effect of case managers is felt both directly and through their role as gatekeepers to a variety of other supportive services (Messeri et al., 2002).

Connecting clients to resources is time-consuming and complex, often involving a mix of advocacy and mediation (Chernesky & Grube, 2000). Even brief interventions by case managers have been associated with significantly higher rates of linkages to HIV care services (Gardner et al., 2005). Clients who have contact with case managers report less unmet need for income assistance, health insurance, home care and emotional counseling (Katz et al., 2001).

In addition to linking clients to services, case managers help clients develop personal support systems, often using themselves as the center of that support (Chernesky & Grube, 2000). A recent Canadian study demonstrated that case management services have reduced client isolation and improved health-related quality of life (Crook et al., 2005).

Case management is integral to medical care. Messeri and colleagues (2002) found that case managers strengthen connections to care by informing clients of the availability of appropriate medical resources, educating them about their benefits and serving as advocates in coordinating medical services and accessing insurance to cover their costs (Messeri et al., 2002). This same New York City study found formal client assessment, the development of a care plan and assistance in securing public benefits to be key factors in significantly increasing the likelihood that a client will enter and maintain medical care (Messeri et al., 2002).

Case management services are important in promoting adherence to treatment (Office of HIV Planning, 2002). Case managers help patients overcome fears about medical treatment, adhere to medication regimens and advocate for themselves with physicians (Katz, et al., 2001). Gasiorowicz and colleagues (2005) found that case management with a prevention

focus significantly decreased reported risk transmission behaviors, including unprotected vaginal intercourse, insertive anal intercourse, and needle sharing.

Finally, case managers can sometimes intervene with entire family systems and provide attention, especially to children, in a way that would not be possible if one of the family members were not living with HIV (Chernesky & Grube, 2000).

SERVICE COMPONENTS

Psychosocial case management services are client-centered activities that coordinate services for people living with HIV to improve health outcomes and facilitate client self-sufficiency. Case managers act as liaisons and advocates for clients in accessing services while educating clients about available resources. Case managers are responsible for understanding service provision systems and advocating for their clients on a public-policy level. Case managers assess and monitor their clients' progress on an ongoing basis. They identify and address client service needs in all psychosocial areas and facilitate the client's access to appropriate resources such as health care, financial assistance, HIV education, mental health and other supportive services that promote. A primary goal of the service is to increase access to and the maintenance of primary medical and supportive services.

Psychosocial case management will respect the inherent dignity of the client. Services will be client-driven, aiming to increase a client's sense of empowerment, self-advocacy and medical self-management, as well as enhancing the overall health status of people living with HIV. All psychosocial case management services will be culturally and linguistically appropriate to the target population (see Program Requirements and Guidelines in the Standards of Care Introduction).

The overall emphasis of ongoing psychosocial case management should be on developing a broad-based support system for the client that makes resources available as needed and encourages client independence to the appropriate degree, given the client's current condition.

Psychosocial case management services Los Angeles County are comprised of individual or family-based services.

OUTREACH

Programs providing psychosocial case management services will conduct outreach activities to potential clients/families and HIV service providers to promote the availability of and access to case management services. Programs will work in Collaboration with HIV primary health care and support services providers, as well as HIV testing sites.

Outreach activities can include (but not be limited to):

- Participation in Service Provider Networks (SPNs)
- Collaborating with other providers
- Posting flyers targeted to potential clients

STANDARD	MEASURE
Psychosocial case management programs will outreach to potential clients/families and providers.	Outreach plan on file at provider agency.

STANDARD	MEASURE
Psychosocial case management programs will collaborate with primary health care and supportive service providers.	Memoranda of Understanding on file at the provider agency.

PSYCHOSOCIAL CASE MANAGEMENT (INDIVIDUAL)

ELIGIBILITY – PSYCHOSOCIAL CASE MANAGEMENT (INDIVIDUAL)

Programs will develop and implement client eligibility requirements that give priority to clients living at or below 100% of poverty level and with the greatest health and service need. Clients who live above 100% of poverty level are also eligible for services, depending upon the threshold for eligibility determined by the Commission's annual priority and allocation decisions. Clients' annual medical and health care expenses are considered deductions against income for purposes of determining their income level. All clients must document their HIV status (or caretaker status) and must show proof of residency in Los Angeles County to be eligible for services. For specific eligibility requirements, refer to the Commission's most recently approved annual HIV/AIDS Service Eligibility Guidelines. If a person is deemed ineligible for case management services, he or she will be referred to appropriate agencies for services.

STANDARD	MEASURE
Eligibility for services will be determined.	Client's file includes: • Proof of HIV diagnosis • Proof of income • Proof of Los Angeles County residence

INTAKE-PSYCHOSOCIAL CASE MANAGEMENT

Client intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client. Programs will assess individuals in crisis to determine what other interventions are appropriate, either within the agency, or by immediate referral.

In the intake process and throughout psychosocial case management delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).

As part of the intake process, the client file will include the following information (at minimum):

- Written documentation of HIV status
- Proof of Los Angeles County residency
- Verification of financial eligibility for services
- Date of intake
- Client name, home address, mailing address and telephone number
- Emergency and/or next of kin contract name, home address and telephone number

Required Forms: Programs must develop the following forms in accordance with State and local guidelines.

Completed forms are required for each client and will be kept on file in the client chart:

- Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- Limits of Confidentiality (confidentiality policy)
- Consent to Receive Services
- Client Rights and Responsibilities
- Client Grievance Procedures

STANDARD	MEASURE
Intake process will begin during first contact with client.	Intake tool in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contract name, home address and telephone number
Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Consent for Services will be completed.	Signed and dated Consent in client file.
Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.

COMPREHENSIVE ASSESSMENT AND REASSESSMENT – PSYCHOSOCIAL CASE MANAGEMENT (INDIVIDUAL)

Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs and resources.

Comprehensive assessment is conducted to determine the:

- Client's needs for treatment and support services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help meet client need
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services

Assessments will be completed and entered into the County's data management system within 30 days of the initiation of case management services. Reassessments will be completed when there are significant changes in a client's status, when the client has left and reentered the case management program, or (at minimum) once per year. Information gathered in comprehensive assessment or reassessment will be used to develop or update the client's ISP.

Case managers will help clients identify and make appointments with medical providers as early as possible during the initial intake process for those clients not already connected to primary medical care.

Assessments and reassessments require the following documentation to be kept on file in the client chart (at minimum):

- Date of assessment or reassessment
- Signature and title of staff person completing the assessment or reassessment

- Client strengths, needs and available resources in the following areas:
  - Medical/health care
  - Medications
  - Adherence issues
  - Physical health
  - Mental health
  - Substance use, history and treatment
  - Nutrition/food
  - Housing and living situation
  - Family and dependent care issues
  - Transportation
  - Language/literacy skills
  - Cultural factors
  - Religious/spiritual support
  - Social support system
  - Relationship history
  - Domestic violence
  - Financial resources
  - Employment
  - Education
  - Legal issues/incarceration history
  - Risk behaviors
  - HIV prevention issues
  - Environmental factors
- Identified resources and referrals to assist client in areas and need
- Client's acuity level and date of acuity assessment

STANDARD	MEASURE

Comprehensive assessments will be completed and entered within 30 days of the initiation of services.
 	
Reassessments will be performed at least once per year or when a client's needs change or he or she has reentered a case management program.
	Comprehensive assessment or reassessment in client chart to include:
	• Date
	• Signature and title of staff person
	• Client strengths, needs and available resources in:
	  • Medical/health care
	  • Medications
	  • Adherence issues
	  • Physical health
	  • Mental health
	  • Substance use, history and treatment
	  • Nutrition/food
	  • Housing and living situation
	  • Family and dependent care issues
	  • Transportation
	  • Language/literacy skills
	  • Cultural factors
	  • Religious/spiritual support
	  • Social support system
	  • Relationship history
	  • Domestic violence
	  • Financial resources
	  • Employment
	  • Education
	  • Legal issues/incarceration history
	  • Risk behaviors
	  • HIV prevention issues
	  • Environmental factors
	• Resources and referrals
	• Client's acuity level and date

Transitional clients will be reassessed as needed.

CLIENT ACUITY LEVEL ASSESSMENT – PSYCHOSOCIAL CASE MANAGEMENT INDIVIDUAL

Client acuity levels will be assessed using all components of the comprehensive assessment and based upon a client's level of functioning and/or current need. Case management staff will use an acuity assessment tool to uniformly determine acuity levels. Case management services will be offered to all clients who meet "high" or "transitional" acuity levels. Other clients will be referred to other sources of care.

Following are brief descriptors of acuity levels that warrant case management services

- **High:** Clients with complex, multiple unmet needs
- **Transitional:** Clients whose acuity level has not yet been determined or who are transitioning out of case management services

High acuity-level clients will be reassessed by case management staff on an ongoing basis. Acuity levels will be updated as needed, at least once per year. Transitional clients will be reassessed as necessary, and within six months will be assessed as high acuity or transitioned out of case management and given appropriate referrals.

STANDARD	MEASURE
Acuity levels will be assigned for all clients.	Completed acuity tool client chart.
"High" and "transitional" acuity-level clients will be offered case management services.	Program monitoring and chart review to confirm.
High acuity clients will be reassessed at least once per year.	Program monitoring and chart review to confirm.
Within six months, transitional acuity clients will be assessed as high acuity or transitioned to outside care.	Program monitoring and chart review to confirm.

INDIVIDUAL SERVICE PLAN (ISP) – PSYCHOSOCIAL CASE MANAGEMENT (INDIVIDUAL)

In conjunction with the client, an ISP is developed that determines the case management goals to be reached. ISPs will be completed for each client within two weeks of the conclusion of the comprehensive assessment or reassessment. ISPs will be updated on an ongoing basis, at least once every six months.

ISPs will include that following (at minimum):

- Name of client and case manager
- Date and signature of case manager
- Date and signature of the client on the initial ISP, and at least once every six months on subsequent ISPs
- Description of client goals, desired outcomes and dates of goal establishment
- Steps to be taken by client, case manager and others to accomplish goals
- Timeframe by which goals are expected to be met
- Disposition of each goal as it is met, changed or determined to be unattainable

STANDARD	MEASURE
ISPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment.	ISP in client chart to include: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Goal timeframes • Disposition of each goal as it is met, changed or determined to be unattainable

IMPLEMENTATION OF ISP, MONITORING AND FOLLOW-UP – PSYCHOSOCIAL CASE MANAGEMENT (INDIVIDUAL)

Implementation, monitoring and follow-up involve ongoing contact and interventions with (or on behalf of) the client to achieve the goals detailed on the ISP, evaluate whether services are consistent with the ISP and determine any changes in the client's status that require updates to the ISP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion.

In the implementation, monitoring and follow-up phases, case managers are responsible for (at minimum):

- Monitoring changes in the client's condition or circumstances, updating/revising the ISP and providing appropriate interventions and linked referrals
- Ensuring that care is coordinated among the client, caregivers and service providers
- Conducting ongoing monitoring and follow-up with clients and providers to confirm completion of referrals, service acquisition, maintenance of services and adherence to services
- Advocating on behalf of clients with other service providers
- Empowering clients to develop and use independent living skills and strategies
- Helping clients resolve any barriers to completing referrals and accessing or adhering to services
- Actively following up on the established goals in the ISP to evaluate client progress and determine appropriateness of services
- Maintaining ongoing client contact at a minimum of one face-to-face or phone contact attempted every month (with one face-to-face contact attempted every three months)
- Actively following up by the end of the next business day with clients who have missed a case management appointment. If follow-up activities are not appropriate or cannot be conducted within the prescribed time period, case managers will document reason(s) for the delay

Current dated and signed progress notes, detailing activities related to implementing, monitoring and follow-up will be kept on file in the client chart.

The following documentation is required (at minimum):

- Description of all client contacts, attempted contacts and actions taken on behalf of the client
- Date and type of contact
- Description of what occurred during the contact
- Changes in the client's condition or circumstances
- Progress made towards achieving goals identified in the ISP
- Barriers identified in ISP goal process and actions taken to resolve them
- Linked referrals and interventions provided
- Current status and results of linked referrals and interventions
- Barriers identified in completing linked referrals and actions taken to resolve them
- Time spent with, or on behalf of, the client
- Case manager's signature and professional title

STANDARD	MEASURE
Case managers will: • Monitor changes in the client's condition • Update/revise the ISP • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on ISP goals • Maintain client contact at a minimum of one contact attempted every month (with one face-to-face contact attempted every three months) • Follow up missed appointments within by the end of the next business day	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent • Case manager's signature and title

FAMILY CASE MANAGEMENT

HIV family case management services are designed to maintain, enhance, or promote family stability and the functional integrity of the family unit.

Services include, but are not limited to:

- Intake and comprehensive assessment of the family's available resources and needs
- Development and implementation of the FSP
- Coordination of services required to implement the FSP
- Interventions, linked referrals, monitoring and follow-up
- Periodic reassessments of the family's status and needs

For purposes of this standard, a family unit is defined as including at least one child and one adult parent or guardian

ELIGIBILITY – FAMILY CASE MANAGEMENT

To be eligible for services, at least one member of the family must be living with HIV. Services to the non-infected members of the family unit shall have at least indirect benefit to the member living with HIV/AIDS by enhancing the health status of this family member.

Programs will develop and implement client eligibility requirements that give priority to clients living at or below 100% of poverty level and with the greatest health and service need. Clients who live above 100% of poverty level are also be eligible for services, depending upon the threshold for eligibility determined by the Commission's annual priority and allocation decisions. Clients' annual medical and health care expenses are considered deductions against income for purposes of determining their income level. All clients must document their HIV status (or caretaker status) and must show proof of residency in Los Angeles County to be eligible for services. For specific eligibility requirements, refer to the Commission's most recently approved annual HIV/AIDS Service Eligibility Guidelines. If a person is deemed ineligible for case management services, he or she will be referred to appropriate agencies for services

STANDARD	MEASURE
Eligibility for services will be determined.	Client's file to include: • Proof of HIV diagnosis • Proof of income • Proof of Los Angeles County residence

INTAKE – FAMILY CASE MANAGEMENT

Family intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, family intake will be completed in the first contact with the potential family. Programs will assess families in crisis to determine what other interventions are appropriate, either within the agency, or by immediate referral.

In the intake process and throughout psychosocial case management service delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information (specification should indicate the type of information that can be released).

Services include individual or family-based services.

As part of the intake process the family chart will include the following information (at minimum):

- Written documentation of HIV status
- Proof of Los Angeles County residency
- Verification of financial eligibility for services
- Date of intake
- Client name, home address, mailing address and telephone number
- Emergency and/or next of kin contract name, home address and telephone number

Required Forms: Programs must develop the following forms in accordance with State and local guidelines.

Completed forms are required for each client and will be kept on file in the client chart:

- Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- Limits of Confidentiality (confidentiality policy)
- Consent to Receive Services
- Client Rights and Responsibilities
- Client Grievance Procedures

STANDARD	MEASURE
Intake process will begin during first contact with family.	Intake tool in family file to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contract name, home address and telephone number
Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.

STANDARD	MEASURE
Consent for Services will be completed.	Signed and dated Consent in family file.
Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in family file.

COMPREHENSIVE ASSESSMENT AND REASSESSMENT – FAMILY CASE MANAGEMENT

Comprehensive assessment/reassessment is completed in a cooperative, interactive face-to-face interview process. Assessment/reassessment identifies and evaluates a family's physical health, mental health, substance use, psychological, financial, environmental, medication, treatment adherence, risk behavior and HIV prevention strengths, needs and resources.

Comprehensive assessment is conducted to determine the:

- Family's needs for treatment and support services
- Family's current capacity to meet those needs
- Ability of the family's social support network to help meet family need
- Extent to which other agencies are involved in family's care
- Areas in which the family requires assistance in securing services

Assessments will be completed and entered into the County's data management system within 30 days of the initiation of family case management services. Reassessments will be completed when there are significant changes in a family's status, when the family has left and reentered the case management program, or (at minimum) once per year. Information gathered in comprehensive assessment or reassessment will be used to develop or update the FSP.

Case managers will assist families to identify and make appointments with medical providers as early as possible during the initial intake process for those clients not already connected to primary medical care.

Assessments and reassessments require the following documentation to be kept on file in the family chart (at minimum):

- Date of assessment or reassessment
- Signature and title of staff person completing the assessment or reassessment
- Family strengths, needs and available resources in the following areas:
  - Medical/health care
  - Medications
  - Adherence issues
  - Physical health
  - Mental health
  - Substance use, history and treatment
  - Nutrition/food
  - Housing and living situation
  - Family and dependent care issues
  - Transportation
  - Language/literacy skills
  - Cultural factors
  - Religious/spiritual support
  - Social support system
  - Relationship history
  - Domestic violence
  - Financial resources

  - Employment
  - Education
  - Legal issues/incarceration history
  - Risk behaviors
  - HIV prevention issues
  - Environmental factors
- Identified resources and referrals to assist family in areas and need

STANDARD	MEASURE

Comprehensive assessments will be completed and entered within 30 days of the initiation of services.
 	
Reassessments will be performed at least once per year or when a family's needs change or a family has reentered a case management program.
	Comprehensive assessment or reassessment in family chart to include:
	• Date
	• Signature and title of staff person
	• Family strengths, needs and available resources in:
	  • Medical/health care
	  • Medications
	  • Adherence issues
	  • Physical health
	  • Mental health
	  • Substance use, history and treatment
	  • Nutrition/food
	  • Housing and living situation
	  • Family and dependent care issues
	  • Transportation
	  • Language/literacy skills
	  • Cultural factors
	  • Religious/spiritual support
	  • Social support system
	  • Financial resources
	  • Employment
	  • Education
	  • Legal issues/incarceration history
	  • Risk behaviors
	  • HIV prevention issues
	  • Environmental factors
	• Resources and referrals

FAMILY SERVICE PLAN (FSP) – FAMILY CASE MANAGEMENT

The FSP determines the course of action in conjunction with the client, including goals to be reached as a result of case management services provided. FSPs will be developed for each family within two weeks of the completion of the comprehensive assessment or reassessment. FSPs will be updated on an ongoing basis, at least once every six months.

FSPs will include the following (at minimum):

- Name of client and case manager
- Date and signature of case manager
- Date and signature of the client on the initial FSP, and at least once every six months on subsequent FSPs
- Description of family goals, desired outcomes and dates of goal establishment
- Steps to be taken by family, case manager and others to accomplish goals
- Timeframe by which goals are expected to be met
- Disposition of each goal as it is met, changed or determined to be unattainable

STANDARD	MEASURE
FSPs will be developed in conjunction with the family within two weeks of completing the assessment or reassessment	FSP on file in family chart that includes: • Name of client and case manager • Date and signature of case manager and client • Date and description of family goals and desired outcomes • Action steps to be taken by family, case manager and others • Goal timeframes • Disposition of each goal as it is met, changed or determined to be unattainable
FSPs will be updated at least once every six months	Updated FSPs on file in family chart

IMPLEMENTATION OF ISP, MONITORING AND FOLLOW-UP – FAMILY CASE MANAGEMENT

Implementation, monitoring and follow-up involve ongoing contact and interventions with or on behalf of the family to achieve goals on the FSP, evaluate whether services are consistent with the FSP and determine any changes in the family's status that require updates to the FSP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion.

In the implementation, monitoring and follow-up phases, case managers are responsible for (at minimum):

- Monitoring changes in the family's condition or circumstances, updating/revising the FSP and provide appropriate interventions and linked referrals
- Ensuring that care is coordinated among the family, caregivers and service providers
- Conducting ongoing monitoring and follow-up with family and providers to confirm completion of referrals, service acquisition, maintenance of services and adherence to services
- Advocating on behalf of families with other service providers
- Assisting families in resolving barriers to completing referrals and accessing or adhering to services
- Actively following up on the established goals in the FSP to evaluate family progress and determine appropriateness of services
- Maintaining ongoing family contact at a minimum of one face-to-face contact every month
- Actively following up within 24 hours with clients who have missed a case management appointment. If follow-up activities are not appropriate or cannot be conducted within the prescribed time period, case managers will document reason(s) for the delay

Current dated and signed progress notes, detailing activities related to implementing, monitoring and follow up, will be kept on file in the family chart.

The following documentation is required (at minimum):

- Description of all client contacts, attempted contacts and actions taken on behalf of the family
- Date and type of contact
- Description of what occurred during the contact
- Changes in the family's condition or circumstances
- Progress made towards achieving goals identified in the FSP
- Barriers identified in FSP goal process and actions taken to resolve them
- Linked referrals and interventions provided
- Current status and results of linked referrals and interventions

- Barriers identified in completing linked referrals and actions taken to resolve them
- Time spent with, or on behalf of, the family
- Case manager's signature and professional title

STANDARD	MEASURE
Case managers will: • Monitor changes in the family's condition • Update/revise the FSP • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of families with other service providers • Help families resolve barriers • Follow up on FSP goals • Maintain at least one face-to-face contact every month • Follow up missed appointments within 24 hours	Signed, dated progress notes on file that detail (at minimum): • Description of family contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the family's condition or circumstances • Progress made toward FSP goals • Barriers to FSPs and actions taken to resolve them • Linked referrals and interventions and current status and results of same • Barriers to referrals and interventions and actions taken • Time spent • Case manager's signature and title

CLIENT RETENTION

Programs shall strive to retain clients/families in psychosocial case management services to ensure continuity of service and retention of clients, programs will be required to establish a broken appointment policy. Follow-up strives to maintain a client's/family's participation in care and can include telephone calls, written correspondence and/or direct contact. Such efforts shall be documented in the progress notes within the client/family record.

In addition, programs will develop and implement a contact policy and procedure to ensure that clients/families that are homeless or report no contact information are not lost to follow-up.

STANDARD	MEASURE
Programs will develop a broken appointment policy to ensure continuity of service and retention of clients/families.	Written policy on file at provider agency.
Programs will provide regular follow-up procedures to encourage and help maintain a client/family in case management services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
Programs will develop and implement client contact policy for homeless clients/families and those with no contact information.	Contact policy on file at provider agency. Program review and monitoring to confirm.

CASE CONFERENCES

Programs will ensure that each case manager participates in group and/or multidisciplinary team case conferences. Case conferences can be conducted in accordance with client supervision or independently from client care-related supervision. Those case conferences conducted independently from client care-related supervision will be discussions of selected clients/families to assist in problem-solving related to clients ISP or FSP goal progress.

Documentation of case conferences held independently of client care-related supervision shall be maintained within each client or family record and include:

- Date of case conference
- Notation that conference is independent from client care-related supervision
- Names and titles of participants
- Psychosocial issues and concerns identified
- Description of guidance and/or follow-up plan
- Results of implementing guidance/follow up

STANDARD	MEASURE
All case managers will participate in case conferences either in client care-related supervision or independently.	Program review and monitoring to confirm.
Independent case conferences will be documented.	Documentation on file in client chart to include: • Date of case conference • Notation that conference is independent of supervision • Names and titles of participants • Issues and concerns identified • Guidance and/or follow-up plan • Results of implementing guidance/follow up

CASE CLOSURE

Programs will ensure that each case manager participates in group and/or multidisciplinary team case conferences. Case conferences can be conducted in accordance with client care-related supervision or independently from client care-related supervision.

Those case conferences conducted independently from client care-related supervision will be discussions of selected clients/families to help clients problem-solve ISP or FSP goal progress such as:

- Meets ISP/FSP goals and has needs resolved
- Relocates out of the service area
- Is ineligible for the service
- No longer needs the service
- Discontinues the service
- Is incarcerated long term
- Uses the service improperly (non-adherence to the ISP/FSP) or has not complied with the client services agreement
- Has died

Case closure summaries will be reviewed, approved and signed and dated by the case management client care supervisor. When appropriate, such summaries will include a plan for client's/family's continued success and ongoing resources to be used.

At minimum, case closure summaries will include:

- Date and signature of case manager
- Date of case closure
- Acuity level assessment at time of case closure
- Status of the ISP/FSP
- Status of primary health care and support service utilization
- Referrals provided
- Reasons for disenrollment and criteria for reentry into services
- Date and signature of client care supervisor

STANDARD	MEASURE
Clients/families will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client/family chart.
Case management cases will be closed when the client/family: • Meets ISP/FSP goals and has needs resolved • Relocates out of the service area • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Uses the service improperly (non-adherence to the ISP/FSP) or has not complied with the client services agreement • Has died	Case closure summary on file in client/family chart to include: • Date and signature of case manager • Date of case closure • Acuity level assessment • ISP/FSP status • Status of primary health care and service utilization • Referrals provided • Reason for closure • Criteria for reentry into services • Date and signature of client care supervisor

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all psychosocial case management staff will be able to provide linguistically and culturally appropriate care to people living with HIV and complete documentation as required by their positions. Case management staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations.

Case managers will hold a Bachelor's degree in an area of human services; a high school diploma (or GED equivalent) and at least one year's experience working as an HIV case manager or at least three year's experience working within a related health services field.

Further, case management staff will have:
- Knowledge of HIV/AIDS and related issues
- Effective interviewing and assessment skills
- Ability to appropriately interact and collaborate with others
- Effective written/verbal communication skills
- Ability to work independently
- Effective problem-solving skills
- Ability to respond appropriately in crisis situations
- Effective organizational skills

All case managers will successfully complete DHSP's Case Management Certification Training within six months of being hired and all recertifications and requisite trainings (as appropriate).

Case management supervision will be provided by a Master's degree-level mental health professional (social work, counseling, nursing with specialized mental health training, psychology, or Doctoral candidate in any of these fields) with case management experience and appropriate professional credentials. Case management supervisors will complete DHSP's Case Management Supervisor Training within six months of being hired.

Case managers will perform their duties according to generally accepted ethical standards including:
- Striving to maintain and improve professional knowledge, skills and abilities
- Basing all services on assessment, evaluation or diagnosis of clients

- Providing clients with a clear description of services, timelines and possible outcomes at the initiation of services
- Safeguarding a client's rights to confidentiality within the limits of the law
- Evaluating a client's progress on a continuous basis to guide service delivery
- Referring clients for those services that the case manager is unable to provide and terminating service with a client when the service is no longer in the client's best interest

Programs increase a client's sense of empowerment.

CLIENT CARE-RELATED SUPERVISION

Supervision is required of all case managers to provide guidance and support. Client care-related supervision will be provided for all case managers at a minimum of four hours per month. Such client care-related supervision may be conducted in individual or group/multidisciplinary team case conference formats. Supervision will be provided by a Master's degree-level mental health professional (social work, counseling, nursing with specialized mental health training, psychology, or Doctoral candidate in any of these fields) with case management experience and appropriate professional credentials.

Client care-related supervision will address clients' psychosocial issues and concerns, provide general guidance and help to develop follow-up plans for case managers. Supervision will help clients problem-solve progress towards goals detailed in the ISP and ensure that high-quality case management services are being provided.

Programs will ensure that each active client is discussed at a minimum of one time per six-month period. For each client discussed, the client care supervisor will address the identified psychosocial issues and concerns, provide appropriate guidance and follow-up plan, and verify that guidance provided and follow-up plan has been implemented.

Client care-related supervision will include the following required documentation to be kept on file in the client chart:

- Date of client care-related supervision
- Supervision format (e.g., individual, group, case conference or multidisciplinary team case conference)
- Name and title of participants
- Psychosocial issues and concerns identified
- Description of guidance provided and case management follow-up plan
- Verification that guidance provided and follow-up plan have been implemented
- Client care supervisor's name, title and signature

STAFF DEVELOPMENT AND ENHANCEMENT ACTIVITIES

Periodic staff training is required to ensure the continued delivery of quality services. Programs will provide and/or allow access to ongoing staff development and training for case management staff. Staff development and enhancement activities will include (but not be limited to) training and/or in-services related to case management issues and HIV/AIDS, including DHSP's Case Management Re-Certification Training Program. Case managers will participate in at least eight hours of job-related education or training annually.

The following documentation, to be kept in the employee record, is required for staff

development and enhancement activities:

- Date, time and location of function
- Function type
- Staff member(s) name(s) attending function
- Name of sponsor or provider of function
- Training outline
- Meeting agenda and/or minutes

STANDARD	MEASURE
Case management programs will hire staff that are able to provide linguistically and culturally appropriate care to clients infected with and affected by HIV.	Resume on file at provider agency to confirm.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's Case Management Certification Training within six months of being hired. Case management supervisors will complete the Supervisors' Training within six months of being hired.	Documentation of Certification completion in employee file.
Staff will participate in recertification training as required by DHSP and in at least eight hours of continuing education annually	Documentation of training employee file to include: • Date, time and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline • Meeting agenda and/or minutes
Case managers will practice according to generally accepted ethical standards.	Program review and monitoring to confirm.
Case management staff will receive a minimum of four hours of client care-related supervision per month from a Master's degree-level mental health professional.	All client care-related supervision documented as follows (at minimum): • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title and signature
Client care-related supervision will provide general guidance and follow-up plans for case management staff.	Documentation of client care-related supervision for individual clients maintained in the client's individual file.

UNITS OF SERVICE

Unit of service: Units of service defined as reimbursement for psychosocial case management services are based on services provided to eligible clients.

- **Individual intake and assessment units:** calculated in number of hours provided
- **Family intake and assessment units:** calculated in number of hours provided
- **Individual service plan development units:** calculated in number of hours provided
- **Family service plan development units:** calculated in number of hours provided
- **Individual service plan implementation, monitoring and follow-up units:** calculated in number of hours provided
- **Family service plan implementation, monitoring and follow-up units:** calculated in number of hours provided
- **Linked referral units:** calculated in number of linked referrals provided

Number of clients: Client numbers are documented using the figures for unduplicated clients within a given contract period.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
DHSP	Division of HIV and STD Programs
FSP	Family Service Plan
GED	General Education Development
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
ISP	Individual Service Plan
SPN	Service Provider Network
STD	Sexually Transmitted Disease